RPMS Suicide Reporting Form

Local Case Number:		Health Record Number:	
Date Form Completed:		DOB/Age:	
Provider Name:		Sex (M/F):	
Date of Act:		Community Where Act Occurred:	

✓	Employment Status	✓	Relationship Status	✓	Education
	Part-time		Single		High School Graduate/GED
	Full-time		Married		Less than High School, highest grade completed:
	Self-employed		Divorced/Separated		Some College/Technical
	Unemployed		Widowed		College Graduate
	Student		Cohabitating/Common-Law		Post Graduate
	Student and employed		Same Sex Partnership		Unknown
	Retired		Unknown		
	Unknown				

✓	Self Destructive Act	✓	Location of Act	✓	Previous Attempts
	Ideation with Plan and Intent		Home or Vicinity		0
	Attempt		School		1
	Completed Suicide		Work		2
	Attempted suicide w/ Homicide		Jail/Prison/Detention		3 or more
	Completed suicide w/ Homicide		Treatment Facility		Unknown
			Medical Facility		
			Unknown		
			Other *(specify):*		

Method (✓ all that apply)					
	Gunshot		*Overdose list:*		Non-prescribed opiates (e.g. Heroin)
	Hanging		Aspirin/Aspirin-like medication		Sedatives/Benzodiazepines/Barbiturates
	Motor Vehicle		Acetaminophen (e.g. Tylenol)		Alcohol
	Jumping		Tricyclic Antidepressant (TCA)		Other Prescription Medication *(specify):*
	Stabbing/Laceration		Other Antidepressant *(specify):*		
	Carbon Monoxide				Other Over-the-counter Medication *(specify):*
	Overdosed Using (select from list)		Amphetamine/Stimulant		
	Unknown		Prescribed Opiates (e.g. Narcotics)		Other *(specify):*
	Other *(specify)*:				

Substances Involved (✓ all that apply)					
	None		Alcohol		Inhalants
	Alcohol & Other Drugs (select from list)		Amphetamine/Stimulant		Non-Prescribed Opiates (e.g. Heroin)
	Unknown		Cannabis (Marijuana)		Prescribed Opiates (e.g. Narcotics)
			Cocaine		Sedatives/Benzodiazepines/Barbiturates
			Hallucinogens		Other *(specify):*

Contributing Factors (✓ all that apply)					
	Suicide of Friend or Relative		History of Substance Abuse/Dependency		Divorce/Separation/Break-up
	Death of Friend or Relative		Financial Stress		Legal
	Victim of Abuse (Current)		History of Mental Illness		Unknown
	Victim of Abuse (Past)		History of Physical Illness		Other *(specify):*
	Occupational/Educational Problem				

✓	Lethality	✓	Disposition	Narrative
	Low		Mental Health Follow-up	
	Medium		Alcohol/Substance Abuse Follow-up	
	High		Inpatient MH Treatment Voluntary	
			Inpatient MH Treatment Involuntary	
			Medical Treatment (ED or In-patient)	
			Outreach to Family/School/Community	
			Unknown	
			Other (specify):	

RPMS Suicide Reporting Form
Instructions for Completing

This form is intended as a data collection tool only. It does not replace documentation of clinical care in the medical record and it is not a referral form. The provider should complete a corresponding RPMS PCC or MH/SS encounter form and update the PCC and/or BH problem lists accordingly. HRN, Date of Act and Provider Name are required fields. If the information requested is not known or not listed as an option, choose "Unknown" or "Other" (with specification) as appropriate.

LOCAL CASE NUMBER:
Indicate internal tracking number if used, not required.

DATE FORM COMPLETED:
Indicate the date the Suicide Reporting Form was completed.

PROVIDER NAME:
Record the name of Provider completing the form.

DATE OF ACT:
Record Date of Act as mm/dd/yy. If exact day is unknown, use the month, 1st day of the month (or another default day), year. If exact date of act is unknown, all providers should use the same default day of the month.

HEALTH RECORD NUMBER:
Record the patient's health record number.

DOB/AGE:
Record Date of Birth as mm/dd/yy and patient's age.

SEX:
Indicate Male or Female.

COMMUNITY WHERE ACT OCCURRED:
Record the community code or the name, county and state of the community where the act occurred.

EMPLOYMENT STATUS:
Indicate patient's employment status, choose one.

RELATIONSHIP STATUS:
Indicate patient's relationship status, choose one.

EDUCATION:
Select the highest level of education attained and if less than a High School graduate, record the highest grade completed. Choose one.

SELF DESTRUCTIVE ACT:
Identify the self destructive act, choose one. Generally, the threshold for reporting should be ideation with intent and plan, or other acts with higher severity.

LOCATION OF ACT:
Indicate location of act, choose one.

PREVIOUS ATTEMPTS:
Indicate number of previous suicide attempts, choose one.

METHOD:
Indicate method used. Multiple entries are allowed, check all that apply. Describe methods not listed.

SUBSTANCE USE INVOLVED:
If known, indicate which substances the patient was under the influence of at the time of the act. Multiple entries allowed, check all that apply. List drugs not shown.

CONTRIBUTING FACTORS:
Multiple entries allowed, check all that apply. List contributing factors not shown.

LETHALITY:
Indicate the level of risk (based on type and location of act, previous number of attempts, method, substance use involved, contributing factors and other clinically relevant information), choose one.

DISPOSITION:
Indicate the type of follow-up planned, if known.

NARRATIVE:
Record any other relevant clinical information not included above.

**** Note: This document should be shredded after electronic entry into RPMS.**

updated: 9/30/05